



Request to Establish Reciprocal Service Credit with an Alternate Plan

| Member Information | | |
|---------------------------|---------------------|-----------|
| Member's Name _____ | SSN _____ | |
| Mailing Address _____ | | |
| City _____ | State _____ | Zip _____ |
| Mobile Phone (____) _____ | Email Address _____ | |

I request that ATRS credit the service from my employment covered by an alternate reciprocal retirement system under ACA § 24-7-801 et. seq. All requests for reciprocal service credit are subject to verification that the service meets eligibility requirements for reciprocal credit and is subject to verification with your participating employer and the reciprocal system or plan in which the service accrued. If you have credit with more than one reciprocal system, submit this form for each reciprocal plan for which you are requesting credit to ATRS.

Name of Alternate Plan _____

Member's Signature _____ Date _____

Certification of Reciprocal System

| To be completed by Arkansas Teacher Retirement System | | |
|---|-----------------------------------|------|
| Member has established service credit of _____ for the period from _____ to _____ | | |
| Years/Months | Date | Date |
| As an employee of _____ | | |
| ATRS Representative Signature | Phone Number and/or Email Address | Date |

| To be completed by Employer | | |
|---|-----------------------------------|------|
| The above member is/was a member of _____ | | |
| Member has established service credit of _____ for the period from _____ to _____, | | |
| Years/Months | Date | Date |
| as a <input type="checkbox"/> Full time <input type="checkbox"/> Part time employee | | |
| As an employee of _____ | | |
| Employer Signature | Phone Number and/or Email Address | Date |

| To be completed by an Alternate Plan Representative | | |
|---|-----------------------------------|------|
| Plan Name _____ | | |
| 1. Has the member received a full or partial distribution? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 2. If yes, please indicate how the funds were distributed and the date of the distribution: | | |
| Date of distribution: _____ | | |
| <input type="checkbox"/> Paid directly to participant | | |
| <input type="checkbox"/> Rolled over to a qualified plan: <input type="checkbox"/> 401(k) <input type="checkbox"/> 401(a) <input type="checkbox"/> 403(b)/457(b) <input type="checkbox"/> Traditional IRA <input type="checkbox"/> Roth IRA | | |
| Alternate Plan Representative Signature | Phone Number and/or Email Address | Date |